RESILIENCE IN THE FACE OF STRESS: GENDER DIFFERENCES IN THE RELATIONSHIP BETWEEN RESILIENCE AND STRESS AMONG LESBIAN AND GAY OLDER ADULTS IN THE AMERICAN SOUTH

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The minority stress model provides context to understand the mechanisms by which prejudicial experiences contribute to the disproportionate prevalence of adverse physical and mental health outcomes among LGBT people. The transactional model of stress and coping explains the appraisal processes through which people identify stigma-related stimuli as threatening and how they assess available coping resources to counteract these threats. The Connor-Davidson Resilience Scale (CD-RISC) and the Perceived Stress Scale (PSS) were used in this study to measure resilience and stress in a sample of 99 lesbian and gay older adults. Women reported statistically significantly higher levels of resilience and lower levels of perceived stress compared to older gay men. An analysis of covariance (ANCOVA) revealed statistically significant main effects for gender (Cohen's d = .51; η_p^2 = .056; $F(1,98) = 5.488$, p = .021) while controlling for perceived stress (Cohen's d = 1.62; η_p^2 = .375; $F(1,98) = 55.840$, $p <$ .001). An interaction effect between gender and perceived stress was also statistically significant (Cohen's d = .72; η_p^2 = .115; $F(1,98) = 12.40$, $p < .001$) indicating that the negative relationship between stress and resilience is stronger for older gay men. Clinical implications and relevance to future research are discussed.

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FOREWORD

I strive to use the most culturally affirming language when referencing groups who hold minoritized or stigmatized identities. I write according to the *Publication Manual of the American Psychological Association*, Seventh Edition guidelines to use person-first language, avoid using adjectives as nouns (e.g., gay people vs. gays), and respect the language people use to refer to themselves. There is little official guidance on using some of these terms, so I draw upon my experiences in community-based research, personal interactions, and the resources below. I would appreciate any opportunity to discuss these word choices and am not opposed to adjusting my language choices following that discussion. Also, I make mistakes, and I welcome feedback and corrections when I do.

Gay/lesbian or *sexual minority* vs. *homosexual*: In recognition of the negative connotation of the word "homosexual" to many lesbian and gay people, I avoid its use. The historical clinical use of this word in pathological contexts makes it offensive to some. Anti-LGBT rhetoric intended to refer to lesbian and gay people derogatorily often includes the word "homosexual" rather than "gay." This word also emphasizes sexual behavior though a person's gay identity may consist of variations of romantic and physical attraction, and may include important cultural affiliations unrelated to sex. Lastly, as a reference to binary biological sex and binary sexual orientation, the terms "homosexual" and "heterosexual" are exclusive of people whose gender identity is not consistent with this conceptualization of sex. For situations in which I believe the context makes the word relevant, as with a discussion of the inclusion of homosexuality [*sic*] as a paraphilic disorder in *DSM-I*, I indicate so with [*sic*].

Straight or *non-sexual minority* vs. *heterosexual*: I use the word "straight" or "non-sexual minority" rather than "heterosexual" as it often seems out of context without reference to the word "homosexual." Like the word "homosexual," it emphasizes sexual behavior and does not encompass all facets of sexual orientation. Lastly, this word also functions in the context of binary sex, which is exclusive of those whose identity is inconsistent with this conceptualization.

Gender vs. *sex*: While these words have different meanings, there are contexts in which they may be interchangeable. In those situations, I use the term gender to avoid exclusionary language associated with a sexual or gender binary and unnecessarily emphasize sex as an identity characteristic (biological sex or sexual behavior).

LGBT vs. LGBTQ: The Q in this acronym usually stands for "queer" or, less often, "questioning." Today, the use of the word *queer* commonly acknowledges a cultural reclaiming of a term previously used as a pejorative. To those who identify as queer, they usually do so with pride. It is also a term sometimes used, though controversially, as an umbrella term that encompasses the full spectrum of gender and sexual identities. However, "queer" can be offensive or cause deep pain for many older generations whose primary interaction with this word was as a hurtful epithet. It is challenging to balance acknowledgment of the pride and feelings of inclusion this word brings to some with acknowledgment of the pain and offense it brings to others. Given that older lesbian and gay people are the focus of this study and as it is intended for them, their loved ones, and professionals who work with them, I use the acronym LGBT here.

Cisgender: This term describes people whose gender-identity matches the gender they

were assigned at birth. This is unlike transgender people whose gender identity is different from what they were assigned at birth. The Latin root “cis” means “same” or “on this side of,” whereas the Latin root “trans” means “across” or “on the other side.” Including the term cisgender in identity descriptions of people who are not transgender is a way of simply validating that diverse gender identities and expressions exist.

Resources

Diana McDonnell, Amy Goldman, & Kristi Kourmjian. (2020). *Asking sexual orientation and identity questions in a respectful and inclusive way | Harder+Company Community Research*. Harder Co Community Research. https://harderco.com/asking-sexual-orientation-and-identity-questions-in-a-respectful-and-inclusive-way/

Gay & Lesbian Alliance Against Defamation. (n.d.). *GLAAD Media Reference Guide - Lesbian / Gay / Bisexual Glossary Of Terms | GLAAD*. Retrieved April 2, 2021, from https://www.glaad.org/reference/lgbtq

Where’s the Q? (n.d.). Coalition for Aging LGBT. Retrieved April 2, 2021, from https://www.cfa.lgbt/wheres-the-q.ht

CHAPTER 1

BACKGROUND

Introduction

The Williams Institute estimates there are approximately 2.4 million LGBT adults over the age of 50 in the United States and that this number is likely to increase to over 5 million by 2030 as cited in Choi and Meyer (2016). Service providers must have the culturally-affirming training and competence to work with this group of older Americans, but evidence suggests a paucity of research addressing these needs as well as gaps in institutional education and training for working with older LGBT people (MacCarthy et al., 2021).

Though there are increased risks of adverse physical and mental health outcomes among older sexual minority men and women, there is much diversity among members of the LGBT community, many of whom have developed unique protective factors to ameliorate these risks. As a result, most older gay and lesbian people are physically healthy and psychologically well-adjusted (Fredriksen-Goldsen et al., 2014). As explained by the minority stress model, however, due to experiences of stigma and discrimination over their life course, many older lesbian and gay people experience depression, anxiety, loneliness, and stress at disproportionate rates compared to their straight counterparts (Meyer, 2003). Nevertheless, it is important to recognize the resilience older members of the LGBT community have built over a lifetime of successfully navigating social stigma, discrimination, and persecution based on their sexual orientation or gender identity (Meyer, 2015). To understand how prejudicial experiences impact health and well-being and the strategies lesbian and gay people engage to counteract them, it is essential to consider gender differences and the historical context in

which older sexual minority adults grew up and formed their sexual identity (Dentato et al., 2014)

Theoretical Framework

Classic personality theories are often insufficient to explain the development of older LGBT people. For example, Erikson's theory of psychosocial development is one of the few personality theories to address development across the entire lifespan (Erikson, 1950/1993). An examination of the unique challenges LGBT people face in each of Erikson's psychosocial stages reveals that it is similarly inadequate to fully explain developmental processes for sexual and gender minority communities across the lifespan. Kimmel (2015) investigates these challenges and proposes that, due to heteronormativity and social stigma, LGBT people rarely overcome the identity struggles of Erikson's theory only once. Instead, they encounter them many times across many contexts throughout their lives. For sexual minority communities, questions of trust, shame, inferiority, identity, and intimacy, to name a few, are encountered at many life stages (Kimmel, 2015).

The homosexual [sic] identity model (Cass, 1979) proposed six stages of identity development including identity confusion, comparison, tolerance, acceptance, pride, and synthesis. Common to many stage models, a criticism of this theory is its assumption that development is linear, sequential, and at some point complete, whereas, in reality, this is often not so of many people's developmental trajectories (Horowitz & Newcomb, 2002). Furthermore, this model was based on research primarily with white men and, therefore, did not account for differences in experiences and identity development among different genders, ethnicities, or other intersectional identities (Chun & Singh, 2010). Thus, another model that

explains the different trajectories and unique challenges LGBT people experience within the context of stigma and social stressors is required.

Minority Stress Theory

Ilan Meyer (2003) proposed a minority stress model to explain the increased prevalence of negative mental health outcomes in LGBT communities compared to their straight and cisgender peers as attributable to the stressful social context of homophobic discrimination and stigma. With consistent exposure to this stigma, some lesbian, gay, and bisexual people turn these negative societal attitudes inward, resulting in internalized homophobia, a type of personal shame about one's sexual identity (Meyer, 1995). Minority stress theory encompasses three primary processes of a) experiencing stressful events, b) vigilance in expectation of these events, and c) internalization of social stigma at the root of these events (Meyer & Frost, 2013). For example, based on past experiences of minority identity-based rejection, one might automatically expect such rejection from others and, over time, come to believe that they are less worthy of acceptance and validation because of their sexual orientation.

These stressful events range from seemingly mundane interactions with a heteronormative society to experiences of overt homophobia (Meyer et al., 2011). Accounting for the total impact of these stressors across the lifespan explains the disproportionate prevalence of adverse mental health outcomes such as depression, anxiety, suicidality, and substance use among sexual minority adults as compared to their straight peers (Diplacido, 1998; Fredriksen-Goldsen et al., 2014; Meyer, 1995). Social stigma as a catalyst for discrimination against sexual minority adults in employment, housing, and access to social services accounts for disparities in financial wealth and economic instability (Mallory et al.,

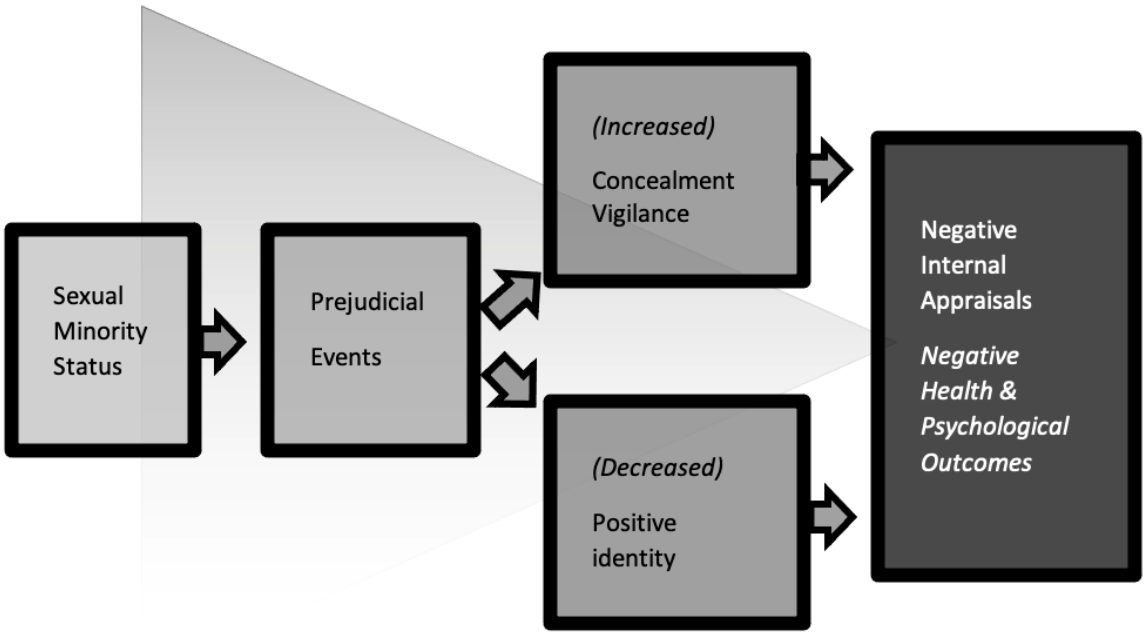
2017). The frequency and degree to which generational cohorts experience these stressors are dependent upon the social climate at the time and place of critical phases of identity development (Grov et al., 2018) and the degree to which they disclose their sexual identity (Legate et al., 2012).

Fredriksen-Goldsen et al. (2017) found that older lesbian and gay people with a positive appraisal of their identity had better social resources, mental health, and physical health than those with poorer identity appraisals. In the same study, marginalization experiences predicted lower available social resources, but only for those with an open identity management style (i.e., those who are the most "out" about their sexual orientation). This finding suggests that highly visible older lesbian and gay people may be disproportionately ostracized, thus negatively impacting their social resources. Nevertheless, Meyer (2011) also found that positive identity development and expression often comes about in response to battling stigma against marginalized identities and the resulting growth of social cohesion and personal power. In other words, resilience often develops in response to minority stress and, for some, may counteract its negative impacts on identity development. At the same time, however, minority stress theory cautions against conceptualizing resilience to minority stress solely in the context of individual-level traits and coping skills, as this may detract focus from the responsibility of society to address discrimination and protect disadvantaged populations (Meyer, 2015). Kwate and Meyer (2010) also explain that because individual-level expectations neglect the importance of equity in public policy, it can lead to policy implications that increase exposure to stressful events and their related negative mental health outcomes. Meyer (2013) further notes the importance of acknowledging both the subjective experiences of minority stress and the

objective stress-inducing social environment. A focus on the latter, he suggests, has a greater impact on the well-being of a minority community in general and places less burden for change on its members. Figure 1 provides a visual depiction of the minority stress model as applied to this study.

Figure 1

Minority Stress Model



Note: This model depicts the negative impacts of sexual identity-based prejudicial events on psychological and health outcomes among sexual minority people.

The Transactional Model of Stress and Coping

Lazarus and Folkman (1984) developed the transactional model of stress and coping to explain cognitive appraisal pathways and coping with stressful events in the person-environment relationship. In the context of aging LGBT people, this model helps clarify differences in appraisals of stress and coping responses compared to their straight or younger counterparts and the impacts of these processes on individual-level resilience factors.

According to the model, in the cognitive appraisal process, a person evaluates whether and to what extent an experience (a transaction) is stressful. Coping involves the process by which one deals with the emotional demands the stressor places upon them. Within this model, stressors are categorized as either distal (social structures) or proximal (personal social experiences). Relevant to minority stress theory, distal stressors include the awareness of heterosexism and exposure to negative social attitudes that LGBT people encounter (Meyer & Frost, 2013). Proximal stressors arise due to their saliency to the person's subjective experience, perceptions, and expectations. In the context of minority stress, distal social structures initially become proximal stressors when individuals first label themselves as gay or lesbian and must evaluate the intrinsic relevance of negative societal messages (Meyer & Dean, 1998).

The transactional model of stress and coping features a cyclical process of appraisals and responses to stressful stimuli. In the *primary appraisal* process, a person labels an encounter as either (1) *irrelevant*, in which they judge it to bear no consequences toward a person's well-being, (2) *benign-positive*, indicating that the encounter serves to either maintain or enhance well-being, or (3) *stressful*, which involves a perception of potential harm, loss, threat, or challenge (Lazarus & Folkman, 1984, p. 32). A stressful primary appraisal is usually followed by a *secondary appraisal*, in which one evaluates available coping resources, potential options, and the likelihood of successfully overcoming or resolving the encounter. The final stage in this process is *reappraisal,* in which a person, having considered their available coping resources, options, and the likelihood of success, reappraises whether the encounter is irrelevant, benign-positive, or stressful.

Lazarus and Folkman (1984) account for different environmental conditions and

individual differences in stress vulnerability, appraisal, and reactions. The primary stressors explored in their model, however, are related to role conflicts, performance, negative interpersonal exchanges, and social structure as opposed to stress from identity-based stigma and discrimination. Major et al. (2003) used a transactional framework to incorporate stress and coping responses in the context of threats to personal identity. The authors propose that *attribution* plays an essential role in the appraisal process. If a person attributes an identity-based threat to unjustifiable discrimination, self-esteem is protected, and self-blame is less likely (Major et al., 2003). In a similar vein, Berjot and Gillet (2011) propose that efforts to protect and enhance personal and social aspects of identity play an important function in coping with identity-based discrimination. With these adaptations, the transactional model of stress and coping fits the person-environment emphasis of the minority stress framework to explain the effects of resilience against sexual identity-based discrimination.

Historical Context

Psychological research in the 20th century reflected the negative views of LGBT people by medical and mental health professionals during that time, which pathologized members of sexual and gender minority communities. Early versions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) informed this research framework with the inclusion of non-heterosexual identities as mental disorders (American Psychiatric Association, 1952). It was not until 33 years later, with the removal of gender identity disorder in *DSM-V*, that the American Psychiatric Association (2013) eliminated the final remnants of official LGBT identity pathology.

Alfred Kinsey's landmark publication "Sexual Behavior of the Human Male" (Kinsey et al., 1948/2003) was critical to both bringing visibility to and normalizing gay and lesbian

relationships and sexual behavior. Legal and social change, however, would still lag far behind these emerging scientific discoveries. The early psychological research framework still bolstered homophobic and transphobic sentiments in American society in the 1950s to 1970s, which viewed members of sexual minority communities as sexual perverts, criminals, and even communists (Messinger, 2006). Oppressive homophobic legislation persisted well into the 21st century. It was out of needs for literal and social survival that LGBT people became very skilled at hiding their identities, and in many cases, denying it even to themselves (Clunis et al., 2005). At a time when gay people experienced physical violence and arrests by police, it was not uncommon for gay and lesbian people to marry someone of the opposite gender as a means of identity concealment and gender role conformity (Butler, 2004).

Lesbian and gay people born in the United States in the 1960s and earlier faced substantial legal, social, and physical threats in the form of state-sponsored persecution due to the marginalization and discrimination of these communities at the time (Field, 2018). The 1969 Stonewall riots in New York were a series of violent confrontations between police and LGBT people, which began in reaction to the repeated arrests of patrons at gay nightclubs, but developed into a days-long protest of discrimination against LGBT people in America. The riots and subsequent protests brought visibility to the second-class citizenship status of LGBT people and spawned hundreds of gay activist organizations across the country. This visibility also brought about a backlash from anti-LGBT people, religious groups, politicians, and law enforcement, who increased raids and arrests at gay clubs across the country (Field, 2018).

Older LGBT people experienced drastic shifts in the political and social climate in the 21st century with the abolishment of homophobic and discriminatory laws that criminalized

homosexuality [*sic*] (*Lawrence v. Texas*, 2003) and denied federal benefits and protections for LGBT people (*Bostock v. Clayton County*, 2020; *Masterpiece Cakeshop v. Colorado Civil Rights Commission*, 2018; *Obergefell v. Hodges*, 2015; *United States v. Windsor*, 2013). Nonetheless, substantial advances toward equality under the law for LGBT Americans often provoke political pushback. In the aftermath of the marriage equality rulings, anti-LGBT politicians mounted lawsuits and proposed state and federal legislation in the form of religious freedom exemption bills, 10th Amendment lawsuits citing federal over-reach of states' rights, and proposed new bills to limit LGBT protections not covered by the Supreme Court rulings (Faderman, 2015).

The AIDS crisis of the 1980s and 1990s was a trying time for gay men. Nearly 450,000 friends, partners and loved ones died of AIDS by the year 2000 (U.S. Centers for Disease Control, 2001). The crisis decimated the thriving LGBT communities in urban areas and further stigmatized gay men as being diseased or sick (Siegel et al., 1998). Tester (2018) found that any older gay men, particularly those in large urban areas, cite the AIDS crisis as a major cause of poor social and community support and feelings of loss. Having survived the AIDS crisis, however, many older gay men also report that the grief and depression they experienced at the time led to discoveries of self-awareness, confidence, and meaning in life (Tester, 2018).

Though the American political landscape has changed dramatically across the lifespan of older LGBT people, researchers must view the impact of these developments on the lives of older LGBT people in a geo-cultural context. When progress toward LGBT equality advances utilizing local and state legislation or by voter mandate, it often reflects changing societal views and may serve to reduce existing anti-gay attitudes (Flores & Barclay, 2016). However, federal judicial action has little impact on the perspectives of those who previously held anti-LGBT

social views (Redman, 2018).

In the American south, expansion of LGBT rights has historically been slower than the rest of the country and less likely to occur through state legislation or voter action. As such, these advancements are often at odds with prevailing social views in the South. As a case in point, despite the recent rapid expansion of rights for LGBT people at the national level, state legislators in Texas, where participants in the present study lived, introduced 32 bills to limit rights and protections for LGBT people, more than any other U.S. state in the 2021 legislative session (Equality Texas, 2021). The political conversation and campaigns related to LGBT rights can take a toll on LGBT people. A media study tested the psychological effects on LGBT people of ads with negative messaging about marriage equality initiatives during the 2012 presidential election (Flores et al., 2018). The study included 12 states, though only four were affected by marriage equality initiatives (i.e., Maine, Maryland, Minnesota, and Washington). Even in states unaffected by marriage equality initiatives, LGBT people exposed to the negative messaging reported higher levels of sadness and a lower likelihood to smile or laugh during the October-November campaign period. Importantly, the issue on these referenda was a proposed expansion of LGBT rights, as opposed to the 32 bills in Texas, which propose to limit existing rights and protections.

Resilience

Resilience is a hallmark strength of LGBT people who have overcome decades of marginalization and discrimination. Resilience is associated with increased social support, self-esteem, general health, psychological well-being, and lower reports of anxiety, depression, and loneliness (Fredriksen-Goldsen, 2011; Lyons, 2015; Reisner et al., 2014). An emphasis on

resilience within LGBT communities in emerging scientific literature reflects a shift toward strengths-based theories of LGBT psychology, and away from deficit-based theories (Herrick et al., 2014; Ramirez & Sterzing, 2017). Indeed, many LGBT people have successfully worked through the challenges of the coming out process, overcome social stigma, and navigated discrimination throughout their lifetime (Schope, 2005). Resilience in the face of such adversity is admirable; and it is important to recognize that this resilience has often come out of necessity and at a significant cost (Russell & Richards, 2003). Meyer cautions against an expectation of such resilience. He warns that victim-blaming can occur by suggesting that "because an individual *can* be resilient, we risk expecting that individuals *ought* to be resilient" (Meyer, 2015, p. 211).

Views in social science literature vary, with some describing resilience as the result of a positive appraisal style (Kalisch et al., 2014), a teachable skill (Richardson & Waite, 2002), a defense mechanism (Davydov et al., 2010), or a function of personality (Oshio et al., 2018). Perhaps most consistent with a minority stress lens relevant to the experiences of LGBT people confronting social stigma and discrimination is a definition of resilience as both "positive adaptation in the face of adversity and risk" and as "a process" (Herrick et al., 2014, p. 2). This view suggests that, rather than an innate set of attributes, resilience is built over the life course and is adaptive with each challenge overcome. This process-oriented framework emphasizes protective factors that foster resilience (Barrow et al., 2007). Bronfenbrenner's (1979) ecological systems theory describes the reciprocal nature of person-environment relationships at various levels of social structure. According to this theory, a microsystem is the environment closest to the individual, as in home or school. In contrast, the macrosystem encompasses the

overarching social, cultural, political and ideological patterns which influence the micro-, meso-, and exosystems (Bronfenbrenner, 1979, pp. 7-8). Conceptualizing this process-oriented approach to the development of resilience within an ecological systems framework helps explain the unique factors that influence resilience in LGBT communities and group differences within them.

Older people in the population at large experience higher levels of resilience and overall wellness than their younger peers (Fullen & Granello, 2018), and the same is true of lesbian and gay older adults (Fredriksen-Goldsen et al., 2011). This is remarkable given the increased physical and mental health disparities older sexual minority adults face compared to their straight peers, including disability, obesity, depression, and loneliness (Fredriksen-Goldsen et al., 2013; Meyer & Frost, 2013). Higher levels of resilience for gay and lesbian older adults compared to their younger gay and lesbian peers may be due, in part, to the more extensive social networks they have created over time, as well as their greater degree of independence and better access to LGBT community resources (Huebner et al., 2004; Kertzner et al., 2009). Older lesbian and gay adults have encountered and often have successfully overcome more experiences of stigma and discrimination in their lifetime, which can bolster resilience in the face of new experiences of minority stress (Crisp et al., 2008; Meyer & Frost, 2013). As compared to their younger peers, resilience buffers many of the disparate identity-based mental health risks faced by lesbian and gay people, internalized stigma, discrimination, and victimization (D'augelli & Grossman, 2001).

The Stonewall Riots of 1969 marked the beginning of the gay activist revolution and a change from the silence and invisibility characteristic of the previous age cohort (Rosenfeld,

1999). This new age of activism began to steadily change previously held notions of family, relationships, opportunity, and self-worth for LGBT people (Dentato et al., 2014). It was still a challenging and dangerous environment to disclose one's sexual minority identity, which many of today's Baby Boomer generation (born 1946-1964), and to a lesser extent, the Greatest Generation (born 1925-1945), did despite the risks. Consequently, prior to the Stonewall Riots, disclosing one's sexual orientation was less common, which both protected against much of the social derision at the time but also deprived them of the critical benefits of belonging, social support, and identity cohesion that often accompanied disclosure (Rosenfeld, 1999). Additionally, coming out during the tumultuous social and political context in the 1960s and 1970s led to the development of what Kimmel (2002) called "Crisis Competence." That is, having faced and survived the heightened stigma, exposure to violence, and threats of job loss and social ostracization that sometimes accompanied sexual identity disclosure in the 1960s and 1970s, people developed resilience to future threats and a higher bar for encounters they label as threats (Kimmel, 2002). The effects of identity concealment and internalized shame likely account for differences in resilience between the Pre- and Post-stonewall cohorts.

Stress

Minority stress and general stress are different in that the latter may be chronic or acute (situational), whereas minority stress is chronic due to its relation to stable social and cultural structures (Meyer, 2003). Crocker (1999) explains that this difference is due to the chronic nature of the stigmatizing social environment, even in the absence of an actual stigmatizing or discriminating event. Minority stress and general stress are related in that minority stress is additive to general stress, thus increasing the stress response to many of the same stressors

that all people face (Meyer, 2003). Allport (1954) described vigilance as a defensive coping mechanism that minority communities use to prepare for and protect against social stigma and discrimination. In response to chronic minority stress, vigilance results in LGBT people remaining in a state of constant alert, thus compounding the stress response (Crocker & Major, 1998).

Though most LGBT people report being in good health, the accumulation of stigma- and discrimination-related stressors across the lifespan is related to poorer reports of overall general health in older lesbian women and gay men (Fredriksen-Goldsen, Kim, Shui, et al., 2017; Lyons et al., 2019; Meyer, 2003). Moreover, sexual minorities experience disparities in the prevalence of adverse physical and mental health such as disability, cardiovascular disease, anxiety, depression, and suicide (D'augelli & Grossman, 2001; Fredriksen-Goldsen, 2011; Kertzner et al., 2009; Meyer, 1995). Minority stress, discrimination, and internalized homophobia are also associated with increased risks of maladaptive coping mechanisms such as smoking, alcohol, and drug use (Averett et al., 2011; Choi & Meyer, 2016; Fenkl, 2012; King et al., 2008).Though resilience helps protect against stress and its related adverse health outcomes, it is not a panacea.

For gay and lesbian people of color, the stress associated with homonegativity and identity-based discrimination is even further compounded. Crenshaw (2018) argued that combined stress associated with multiple minority identities is not just additive, but that discrimination from multiple systems of oppression intersect such that these experiences of discrimination are greater than the sum of their parts. For Latinx men, this stress is associated with psychological distress, poor general health, and sexual risk behaviors (Nakamura & Zea,

2010). The stigma Black men experience from within Black communities, and the racism they encounter in LGBT communities are detrimental to social and community support, and often prevent them from seeking HIV prevention services (Haile et al., 2011). Associated with compounding minority stress, Black women report lower health-related quality of life than straight White and Black women as well as lesbian White women (Cohen & Murray, 2006).

Gender

Despite commonalities in their encounters with sexual minority-based marginalization and discrimination, researchers must not assume that older lesbian women and gay men experience the same types of discrimination events or that they are affected by and cope with these experiences similarly (Averett & Jenkins, 2012). Acknowledging commonalities between older lesbian women and gay men should not mean ignoring differences, particularly given the patriarchal social and political structures in the U.S. that contribute to the invisibility of women, including within LGBT communities (Brown, 2009).

For members of multiple intersecting minority communities, each of these minority statuses has varying degrees of salience to their identity (Yakushko et al., 2009). For older lesbian women, this diversity of identity salience may also play a role in the frequency, degree, and types of discrimination they encounter (Hughes & Hurtado, 2018; Yakushko et al., 2009). Having experienced some degree of discrimination across their lifetimes based on each of these identities, however, older lesbian women may have developed more coping mechanisms and greater resilience than older gay men as a result (Lyons et al., 2019). In addition, the triple invisibility of older lesbian women, along with the sexual fetishizing of lesbian women by straight men (Diamond, 2005; Kehoe, 1986), may play a role in older lesbian women reporting

fewer experiences of homophobic discrimination as compared to older gay men (Lyons et al., 2019).

Research findings on gender differences in stress levels between men and women in the population at large are mixed, and differences are often context-dependent (Juster et al., 2019; Matud, 2004; Thoits, 1982). The contexts under which women report higher levels of stress are often related to gender roles and family structures (Juster et al., 2019; Matud, 2004), situations that may be markedly different for gay and lesbian people. That said, discrimination predicts higher psychological distress and poorer physical health among gay men compared to women, although the directionality of the relationship between discrimination and poor health is unclear (Lyons et al., 2019). This stronger relationship between discrimination and psychological distress for gay men may be due to more effective emotion-focused coping styles leveraged by women (Matud, 2004) or differences in the types of discrimination gay men and lesbian women experience.

Older gay men are more likely than lesbian women to experience acts of violence due to sexual orientation discrimination across their lifespan, usually by straight men (D'augelli & Grossman, 2001; Grossman et al., 2001). Such violence may be due to homophobia combined with particularly narrow perceived social norms for expressions of masculinity (Coston & Kimmel, 2012). Considerations of historical context are also essential here, as homophobic laws, such as those criminalizing sodomy, targeted gay men more directly than lesbian women. The AIDS crisis of the 1980s was particularly impactful in the lives of older gay men in many ways. Whether they had AIDS or not, they were targets of the social stigma and political polarization of the AIDS crisis (Meyer, 1995). Homophobia in social and political discourse

predicts the internalization of identity-based shame. It is not surprising then that older gay men report higher levels of internalized homophobia than their lesbian agemates (Grossman et al., 2001), or that the relationship between discrimination and wellbeing is stronger for men than women (De Graaf et al., 2006).

Present Study

Research on aging LGBT populations is gaining focus with increased sensitivity to intersectionality in the social sciences, and interest in the largest generational cohort in the U.S., the Baby Boomers, as they enter retirement. Emerging research resists temptations to treat the LGBT community as monolithic, recognizing the different experiences and divergent trajectories of those with diverse genders, gender identities, and sexual orientations across the age spectrum. LGBT research has also moved toward strengths-based theoretical and applied research, as opposed to the deficit-based theories of previous decades.

It is with these foci that I conducted the present study. I examined gender differences between lesbian women and gay men as related to resilience and stress. I leveraged the transactional model of stress and coping (Lazarus & Folkman, 1984) to understand the processes by which older lesbian women and gay men have been able to cope with adversity and build resilience through Meyer's (2003) minority stress theoretical framework. Given the historical period in which older lesbian women and gay people came of age and formed their identities, resilience has likely played an important role in their survival and wellbeing across the lifespan. Older lesbian women hold multiple minority identities which each interact differently with stress. Also, gender role distinctions between older lesbian and older straight women may suggest that the sources of and degrees of gender-related stress are different.

Given the mixed results in the literature about gender differences in stress in the general population and the compounding nature of minority stress due to multiple minority identities for older lesbian women, an interaction between gender and stress may affect levels of resilience. That is to say that simply examining differences in mean scores of resilience between groups may not reveal the effects of different frequencies and degrees of general stress, as compounded by minority stress, on measures of resilience. To that end, I examined gender differences in resilience while controlling for stress and analyzed the interaction of gender and stress on resilience. Specifically, I tested the following hypotheses.

Hypothesis 1: Older lesbian women report significantly higher levels of resilience and significantly lower levels of perceived stress than older gay men.

Hypothesis 2: There is an overall negative relationship between levels of perceived stress and resilience.

Hypotheses 3: An interaction effect of gender and levels of perceived stress exists, such that the negative relationship between stress and resilience is stronger in older gay men.

CHAPTER 2

METHOD

Participants

The total sample consisted of 113 participants. The sample included 12 transgender individuals, but due to an unfortunate design error, these participants were unable to disclose their sexual orientation which made their data unusable in the present study. The remaining sample included 101 older lesbian women and gay man who met eligibility criteria. I excluded two cases after identifying invalid response patterns which left a total of 99 participants consisting of 50 women and 49 men. Participants ranged in age from 50 to 81 (*M* = 58.9, *SD* = 6.5), with 68 identified as White/European American (68%), 17 as Black/African American (17%), 8 as Hispanic/Latinx (8%), 4 as Asian American/Pacific Islander (4%), and 2 as multiracial (2%). The median household income was $40,000-$50,000.

Instruments

Prior to scheduling potential participants, research assistants emailed or called them with a brief survey to ensure they met the eligibility criteria. To meet these criteria participants were 50 years of age or older, identified as lesbian or gay, and read and write fluently in English. Demographic information collected as part of the computerized survey included age, ethnicity, gender, sexual orientation, and household income.

Connor-Davidson Resilience Scale (CD-RISC)

The Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) measures resilience, defined as a person's ability to cope with and manage challenging and stressful life

events. While “process” resilience is an emerging conceptualization of resilience developing from a set protective factors and environmental supports, most widely-used resilience measures primarily assess abilities and personality characteristics that promote resilience (Asheim et al., 2020). Herman et al (2011) proposed a resilience process model that focuses on interactions between personal factors such as growth from adversity, as well as environmental-systemic factors including social support, close relationships, and spirituality. Although largely focused on individual factors, the CD-RISC taps in to these content domains including gaining confidence from past successes, close and secure relationships, and knowing where to turn for help (Connor & Davidson, 2003). An example item is, “My past successes give me confidence for new challenges.” The CD-RISC consists of 25 items on a 5-point Likert-type scale with responses from 0 (*not at all true*) to 4 (*true nearly all of the time*), with scores ranging from 0 to 100, with higher scores indicating greater resilience. It demonstrates internal consistency reliability ($\alpha = .89$), test-retest reliability ($r = .87$), as well as convergent and divergent validity (Connor & Davidson, 2003).

Perceived Stress Scale (PSS)

The Perceived Stress Scale (PSS) measures the degree to which situations in one’s life are appraised as stressful over the past month (Cohen, Kamarck, & Mermelstein, 1983). An example item is, “In the last month, how often have you felt that you were unable to control the important things in your life?” Scores are measured on a 5-point Likert-type scale with answers ranging from 0 (*never*) to 4 (*very often*), and total scores range from 0 to 56, with higher scores indicating higher levels of stress appraisal. Cohen et al. (1983) found that the PSS

demonstrates internal consistency reliability (α = .84-.86) and test-retest reliability (*r* = .85). Cohen & Williamson (1998) also reported convergent and construct validity.

Procedures

A power analysis with using G-Power indicated a total sample size of 90 participants was necessary for an ANCOVA to detect an effect size of .30 with 95% confidence (*p* = .05) using two groups in the independent variable and three covariates. Data for this study is part of Project Grey Pride, a research study designed to identify strengths and challenges faced by aging lesbian and gay people. Following approval from the university's Institutional Review board, the researchers recruited lesbian and gay participants over the age of 50 who were fluent in English. Researchers recruited participants from the Dallas-Fort Worth Metropolitan Area from community centers, churches, Gay Pride events, and through online social networks. Interested participants contacted our team by email or phone.

Eligible participants met face-to-face with research assistants at community centers or libraries in the DFW area in groups of up to 3. After providing informed consent, participants completed a computerized survey on laptop computers provided by the research team using the Questionnaire Data System (QDS). All QDS data is anonymously stored on a password-protected hard drive in a locked research office. After completing the survey, participants received a $25 cash participation incentive funded by a faculty research grant from the primary investigator's university. Researchers asked participants to share the contact information of acquaintances they thought might be interested in participating in this study or asked them to share the research team's contact information with their acquaintances to allow for further snowball sampling.

Analyses

I used the IBM Statistical Package for the Social Sciences version 27 (SPSS 27) to conduct all analyses. Analysis of covariance (ANCOVA) combines the statistical tests of analysis of variance (ANOVA) and multiple regression to increase explanatory power and reduce error variance by adjusting levels of a dependent variable amongst groups for the variance attributable to covariates (Tabachnick & Fidell, 2019). I used ANCOVA to test the degree to which gender differences, the independent variable (IV), account for variance in resilience, the dependent variable (DV), while controlling for covariates (CVs) which included perceived stress, income, and ethnicity in older lesbian women and gay men. The resulting analysis provides a means of identifying gender differences in resilience while controlling for covariates. The ANCOVA also identifies how gender differences in stress interact with resilience.

CHAPTER 3

RESULTS

Data Preparation

A missing value analysis using SPSS 27 revealed no missing data among any variables of interest or demographic factors for any participants (*N* = 101), thus requiring no data estimation or imputation. A review of data identified two cases with potentially corrupted data due to answer choice patterns of all zeros. As the resilience scale items do not contain any reverse-scored or recoded items, these scores are possible, and it is difficult to determine whether these responses reflect a genuine response from these participants. Upon further investigation, this response pattern was consistent among other scales that include forward- and reverse-scored items, which were presented before and after the survey's resilience items. Answering reverse-scored items with identical extreme responses for forward-scored items (all zeros in these cases) indicates a lack of attentive response. Therefore, I deleted these two cases leaving a total of 99 cases for this analysis. Cronbach's alphas for the resilience and perceived stress measures indicated acceptable reliability for both as shown in Table 1.

Table 1

Reliability Coefficients

Instrument	α	Number of items	Possible Range	Sample Range	Sample Mean	Sample SD
Resilience (CD-RISC)	.82	25	0-56	3-39	76.44	15.9
Stress (PSS)	.95	14	0-100	25-100	19.8	8.1

Note. α = Cronbach's alpha

Table 2

Demographic Characteristics

Demographics	Men		Women		Total	
	n	%	n	%	n	%
Gender	49	49.5	50	50.5	99	100
Ethnicity/Race						
White or European-American	27	55.1	40	80.0	67	67.7
Black or African American	13	26.5	4	8.0	17	17.2
Hispanic or Latino/a	4	8.2	4	8.0	8	8.1
Asian or Asian American	3	6.1	1	2.0	4	4.0
Biracial	0	0	1	2.0	1	1.0
Multiracial (more than 2)	1	2.0	0	0.0	1	1.0
Other	1	2.0	0	0.0	1	1.0
Household Income Before Taxes						
Less than $10,000	5	10.2	1	2.0	6	6.1
$10,000 - $14,999	4	8.2	2	4.0	6	6.1
$15,000 - $19,999	8	16.3	1	2.0	9	9.1
$20,000 - $29,999	9	18.4	8	16.0	17	17.2
$30,000 - $39,999	6	12.2	3	6.0	9	9.1
$40,000 - $49,999	3	6.1	5	10.0	8	8.1
$50,000 - $69,999	4	8.2	12	24.0	16	16.2
$70,000 - $99,999	6	12.2	2	4.0	8	8.1
$100,000 or more	4	8.2	16	32.0	20	20.2
	M	SD	M	SD	M	SD
Age	57.9	7.16	59.6	5.79	58.9	6.54
Years of Education Completed	15.8	3.29	16.3	2.91	16.1	3.10

Table 2 details demographic characteristics of this sample. To determine whether statistically significant differences in demographic variables exist between men and women, I computed t-tests on age, years of education, income, as well as a chi square test on ethnicity. T-

tests revealed no statistically significant differences between men and women in age (t = -1.498, p = .138) or years of education (t = -.776, p = .440). There were, however, statistically significant differences between men and women in income (t = -3.847, p < .001) and ethnicity (χ^2 = 8.56, p = .036). Due to the low numbers of participants in each ethnicity category, I created a dichotomous ethnicity variable to distinguish White or European American participants (n = 67) from participants of all other ethnicities (n = 32). I added this variable and the continuous income variable (measured in ranges) as covariates in the ANCOVA.

Means, standard deviations, and measures of distribution normality for resilience, perceived stress, and income are reported in Table 3. Additional analyses indicated that the dataset met the necessary assumptions prescribed by Tabachnick and Fidel (2019) to conduct an ANCOVA. These include equal sample sizes, normality of distributions at each level of the independent variable, linearity between the covariate and dependent variable, homogeneity of variance between groups, homogeneity of regression slopes, homoscedasticity of error variance, and reliability of covariates.

After removing the two cases with corrupted data, the sample sizes are very nearly equal (males, n = 49; females, n = 50). ANCOVA is robust against such minor differences, especially when conducting tests using a general linear model (Tabachnick & Fidell, 2019), as is the case here. Descriptive analyses presented acceptable levels of skewness and kurtosis for all variables within each group, each falling within $^{+}$/- 1.96 when divided by their standard errors. Boxplot analyses confirmed that there were no outliers in the dataset. A scatterplot matrix displayed elliptically arranged data in both groups for all variables, indicating linear relationships between the covariates and the dependent variable. Bivariate correlation analyses

to test for collinearity indicated that income is correlated with perceived stress (r = -.41, p < .001), but ANCOVA is robust against collinearity when r < .50 (Tabachnick & Fidell, 2019). There was no statistically significant relationship between ethnicity and perceived stress.

Table 3

Descriptive Statistics and Distribution Analyses

	PerceivedStress	Income	Resilience
		Male	
Mean	22.43	$20k-$40k	70.98
Std. Deviation	7.49	2.46	18.64
Variance	56.13	6.06	347.35
Variance Ratio[a]	1:1.2	1:1.2	1:3.3
Skew	-0.04	0.24	-0.42
SE_{Skew}	0.34	0.34	0.34
Skew/SE_{Skew}	-0.12	0.71	-1.24
Kurtosis	0.00	-1.03	-0.52
$SE_{Kurtosis}$	0.67	0.67	0.67
Kurtosis/$SE_{Kurtosis}$	0.00	-1.54	-0.78
Range	36.00	$100k+	75.00
		Female	
Mean	17.32	$30k-$50k	81.76
Std. Deviation	7.94	2.25	10.26
Variance	63.00	5.07	105.33
Variance Ratio[a]	1:1.1	1:1.2	1:3.3
Skew	0.64	-.613	-0.23
SE_{Skew}	0.34	0.34	0.34
Skew/SE_{Skew}	1.88	-1.80	-0.68
Kurtosis	0.10	-0.55	-0.56
$SE_{Kurtosis}$	0.66	0.66	0.66
Kurtosis/$SE_{Kurtosis}$	0.15	-0.83	-0.85
Range	33.00	$100k+	41.00

(table continues)

Ethnicity						
	Men		Women		Total	
	N	%	*N*	%	*N*	%
White or European American	27	55.1	40	80.0	67	67.7
Other Ethnicity	22	44.9	10	20.0	32	32.3

Note. [a]Variance ratio is a comparison of the difference in variance between groups.

Levine's test resulted in a statistically significant result ($F = 4.129$, $p = .045$), indicating a lack of homogeneity of variance. Tabachnick and Fidell (2019) note, however, that tests of heterogeneity of variance are not needed if, 1) the variance ratio between groups is less than 10:1, 2) the ratio of the difference between sample sizes in this dataset is less than 4:1, and 3) no outliers are present. Variance ratios in this sample met this variance ratio criterion at 1.1:1 for perceived stress, 1.2:1 for income, and 3.3:1 for resilience. Meeting these criteria indicates the ANCOVA should be robust despite the presence of heterogeneous variance.

Testing equality of regression slopes between groups using a split-file linear regression revealed a difference between perceived stress and resilience slopes of .179 (Males, β = -0.695; Females, β = -.516) and a difference between income and resilience slopes of .067 (Males, β = .163; Females, β = .230). Wu's (1984) Monte Carlo analyses provided evidence that when the difference between group slopes is less than .4, ANCOVA is robust against unequal regression slopes, as is the case in this analysis. An *F*-test for heteroscedasticity was not statistically significant for either men ($F(1,47) = 1.593$, $p = .213$) or women ($F(1,48) = 1.903$, $p = .174$), indicating that error variances were homogenous. The final assumption of ANCOVA is that the covariates are reliable. Reliability coefficients for perceived stress (Cronbach's $\alpha = .82$) and resilience (Cronbach's $\alpha = .95$) both demonstrate adequate reliability. Despite minor

assumption violations, all of which are in acceptable ranges within which ANCOVA remains robust, the data meet requirements to proceed with the analysis.

Primary Analyses

The primary analysis involved conducting an ANCOVA utilizing the general linear model within SPSS 27, the results of which are detailed in Table 4. The study included total resilience scores as the dependent variable, analyzed by the fixed factor gender as the independent variable, controlling for perceived stress scores, income, and ethnicity as the covariates. To test the hypothesis of an interaction between gender and stress, a *genderXstress* interaction term was also included in the model to identify the amount of variance accounted for by this interaction.

Table 4

ANCOVA Tests of Between-Subjects Effects

Source	*F*	Sig.	η_p^2	Cohen's *d*
Gender	5.49	.021	.056	.51
Perceived Stress	55.84	<.001	.375	1.62
Gender * Perceived Stress	11.51	.001	.110	.72
Ethnicity	.01	.925	.000	.00
Income	.04	.845	.000	.00

Note. $R^2_{\text{Adjusted}} = .482$, $p < .001$

In support of Hypothesis 1, women reported statistically significantly higher levels of resilience than men (Women, *M* = 81.8, *SD* = 10.26; Men, *M* = 70.98, *SD* = 18.64; *t* = -3.55, *p* < .001) and lower levels of stress (Women, *M* = 17.3, *SD* = 7.94; Men, *M* = 22.4, *SD* = 7.49; *t* = 3.29, *p* < .001). Results of the ANCOVA indicated that gender accounted for approximately 6%

of the variance in resilience in this model (η_p^2 = .056; $F(1,98) = 5.488$, p = .021) constituting a medium effect size (Cohen's d = .52).

Supporting Hypothesis 2, resilience is negatively associated with levels of perceived stress. There is a statistically significant negative main effect of stress on resilience, with levels of stress accounting for about 38% of variance in resilience (η_p^2 = .375; $F(1,98) = 55.840$, p < .001) constituting a large effect size (Cohens d = 1.62). Additional added covariates included income and ethnicity as there were statistically significant gender differences in these variables. The ANCOVA indicated that neither income (η_p^2 < .001; $F(1,98) = 0.039$, p = .845) nor ethnicity (η_p^2 < .001; $F(1,98) = .009$, p = .925) were statistically significant in this model.

Finally, the presence of a statistically significant interaction effect between gender and stress supports Hypothesis 3, as detailed in Table 4. This interaction accounts for approximately 12% of the variance in resilience (η_p^2 = .115; $F(1,98) = 12.40$, p < .001) and constitutes a medium effect size (Cohen's d = .72). The interaction confirms that the negative relationship between stress and resilience is stronger for men than women in this sample.

To aid in explaining these results, I compared group means for relationship status and analyzed the incidence of HIV seropositivity among gay men in the sample. These variables may explain differences in stress and resilience in older gay and lesbian adults. These results are presented in Table 5 along with tests of gender effects for other individual characteristics.

To interpret the lower resilience and higher stress scores in men as compared to women, I explored potential within-group factors that might help interpret these findings. As HIV seropositivity and holding ethnic minority identities are correlated with these score patterns, I evaluated these demographic variables within the male group. Comparing older gay

men who were HIV+ (*n* = 25) to men who were HIV- (*n* = 24), there were no statistically significant differences in resilience (HIV+, *M* = 72.5, *SD* = 20.57; HIV-, *M* = 69.4, *SD* = 16.7; *t* = -.586, *p* = .560) or perceived stress (HIV+, *M* = 23.1, *SD* = 6.8; HIV-, *M* = 21.7, *SD* = 8.2; *t* = -.655, *p* = .515).

Table 5

Tests of Gender Effects in Individual Characteristics

Characteristic	Men		Women		*t*	Sig.
	M	*SD*	*M*	*SD*		
Age	57.9	7.16	59.6	5.79	1.498	.138
Education (yrs)	15.8	3.29	16.3	2.91	.776	.440
Income	$20k-$30k	2.46	$30k-$50k	2.25	-3.849	<.001
	n		*n*			
Partnered[a]	20		36		-3.261	.002
Ethnic Minority[b]	22		10		2.713	.008
HIV+	25		0		7.071	<.001

Note: [a]Partnered includes married, living together, or in a committed relationship. [b]Ethnic Minority is a dichotomous variable to indicate any minority ethnicity.

Most of the people of color in this sample were men (*n* = 22) as compared to women (*n* = 10), so ethnicity effects are more likely within the male group. Comparing older gay men who identified as an ethnic minority (*n* = 20) to those who did not (*n* = 29), there were no statistically significant differences in resilience (Ethnic minority, *M* = 74 *SD* = 19.28; Ethnic majority, *M* = 68.7, *SD* = 18.03; *t* = -1.080, *p* = .190) or perceived stress (Ethnic minority, *M* = 20.9, *SD* = 7.17; Ethnic majority, *M* = 23.70, *SD* = 7.17; *t* = 1.330, *p* = .190).

To better understand specific domains that could account for gender differences in resilience and perceived stress, I evaluated gender differences in item-level mean scores of the

measures for both variables, as detailed in Tables 6 and 7. For the Perceived Stress Scale, there were statistically significant gender differences in 8 of the 13 items, men scored higher than women on all 8. Six items had similarly high difference scores (0.51 to 0.61) which related to feeling a lack of control (Items 7, 2, and 9) and lack of ability to cope with stressors (Items 6 and 5). For the Connor-Davidson Resilience Scale, there were statistically significant gender differences in 19 of the 25 items, and men scored lower than women on all of these. The greatest difference by far was with Item 2, "I have close and secure relationships" (Men, M = 2.7, SD = 1.36; Women, M = 3.7, SD = 0.49; t = -5.125, p < .001).

Table 6

Perceived Stress Scale Item-level Gender Differences

Item	Domain	Men		Women		Diff	*t*	Sig
		Mean	*SD*	Mean	*SD*			
7*	Control	1.4	1.10	0.8	0.74	0.61	3.239	.002
6*	Coping resources	1.2	1.08	0.6	0.67	0.58	3.246	.002
5*	Coping resources	1.3	1.09	0.8	0.68	0.55	3.006	.003
2	Control	1.8	1.01	1.3	0.93	0.54	2.746	.007
9*	Control	1.5	1.08	1.0	0.77	0.51	2.706	.008
1	Unpredictable events	1.9	0.92	1.5	0.68	0.42	2.571	.012
4*	Coping resources	1.3	1.11	0.9	0.84	0.41	2.057	.042
8	Coping Resources	1.6	1.04	1.2	0.90	0.39	2.003	.048
11	Control	1.8	0.92	1.5	0.79	0.32	1.832	.07
10*	Overloaded	1.4	0.93	1.1	0.85	0.31	1.713	.09
3	Experienced stress	2.0	1.13	1.7	0.94	0.30	1.438	.154
14	Overloaded	1.4	1.02	1.1	0.87	0.29	1.51	.134
12	Experienced stress	2.6	1.00	2.7	0.76	-0.13	-0.719	.474
13*	Control	1.1	0.94	1.1	0.77	0.02	0.132	.895

Note. This table is sorted by items with the greatest gender difference to the least. *Denotes positively-valenced items that are reverse scored so that higher scores indicate higher perceived stress.

Table 7

Connor-Davidson Resilience Scale Item-level Gender Differences

Item	Domain	Men		Women		Diff	*t*	Sig
		Mean	*SD*	Mean	*SD*			
2	Secure relationships	2.7	1.36	3.7	0.49	-1.05	-5.125	<.001
20	Trusting instincts	2.0	1.03	2.7	0.83	-0.74	-3.925	<.001
21	Control	2.6	1.17	3.2	0.69	-0.67	-3.470	.001
16	Competence	2.5	1.19	3.1	0.75	-0.63	-3.159	.002
14	Trusting instincts	2.8	1.10	3.3	0.68	-0.52	-2.855	.005
5	Accepting change	2.8	1.18	3.4	0.69	-0.52	-2.699	.008
17	Competence	2.9	1.09	3.4	0.61	-0.52	-2.960	.004
4	Accepting change	3.0	1.09	3.5	0.61	-0.50	-2.822	.006
11	Competence	3.0	0.97	3.4	0.61	-0.46	-2.835	.006
6	Trusting instincts	3.0	0.91	3.5	0.73	-0.46	-2.759	.007
7	Trusting instincts	2.6	0.99	3.1	0.83	-0.45	-2.434	.017
24	Competence	2.8	1.07	3.3	0.67	-0.44	-2.479	.015
8	Accepting change	3.0	1.14	3.4	0.54	-0.44	-2.468	.015
3	Spiritual influences	2.7	1.37	3.1	1.14	-0.43	-1.681	.096
19	Trusting instincts	2.8	0.94	3.2	0.62	-0.42	-2.670	.009
22	Control	2.8	1.07	3.2	0.82	-0.40	-2.109	.038
13	Control	3.1	1.10	3.5	0.68	-0.40	-2.180	.032
15	Trusting instincts	2.6	1.08	3.0	0.80	-0.39	-2.041	.044
18	Trusting instincts	2.9	0.98	3.3	0.63	-0.36	-2.182	.032
23	Competence	2.6	1.08	2.9	0.84	-0.33	-1.688	.095
12	Competence	3.1	0.93	3.4	0.64	-0.32	-1.986	.050
10	Competence	3.4	0.78	3.5	0.50	-0.19	-1.468	.145
25	Competence	3.2	0.93	3.4	0.67	-0.18	-1.079	.283
9	Spiritual influences	3.0	0.98	3.0	1.02	0.02	0.104	.918
1	Accepting change	3.1	0.97	3.1	0.81	0.02	0.125	.901

Note. This table is sorted by items with the greatest gender difference to the least.

CHAPTER 4

DISCUSSION

The purpose of this study was to investigate gender differences in resilience among older lesbian women and gay men in the American South as well as explore how stress and gender interact with respect to levels of resilience. Specifically, the design of the study examined main effects of gender and stress on resilience as well as effects of an interaction between gender and stress on resilience. While the literature on gender differences in stress and resilience in the general population are inconsistent, even less is known about these differences among older lesbian women and gay men.

As a hallmark strength of lesbian and gay people, resilience has been built across the lifespan as older lesbian women and gay men encountered and coped with stigma, marginalization, and discrimination. The transactional model of stress and coping (Lazarus & Folkman, 1984) is useful in understanding how overcoming these prejudicial events is related to increased resilience and coping mechanisms. For older people in the general population, this positive correlation between adversity and resilience is dependent on coping resources and social networks (Hildon et al., 2008), which are often different for older lesbian women and gay men compared to their straight peers (Kwon, 2013). It is important to consider the role minority stress plays in the ability to access social spaces and networks, and how the compounding nature of minority stress increases the effects of everyday stressors, placing additional strain on available coping resources. While resilience plays a clear role in the success with which older lesbian and gay people have overcome adversity, Meyer (2015) cautions against the perception that resilience is sufficient for LGBT people to cope with prejudicial events in society. Such an

opinion may lead to victim blaming rather than addressing the social causes of minority stressors.

In the present study, perceived stress emerged with the strongest negative relationship to resilience (Cohen's *d* = 1.62) among the variables of interest. Though directionality and causal inferences should not be assumed, the strength of this relationship is consistent with recent findings in the general population (Thoma et al., 2020; Zapater-Fajarí et al., 2021). This relationship is especially salient to those who experience additional stress due to holding one or many minority identities (Kertzner et al., 2009). Though successfully navigating adversity throughout one's life is related to increased resilience, the disproportionately heightened levels of perceived, or felt stress, among older lesbian women and gay men presents a threat to this important strength.

Though older lesbian women in this study reported significantly higher levels of resilience than older gay men, gender only accounted for about 6% of the variance in resilience. The presence of an interaction effect between gender and stress, which accounted for 11% of variance in resilience, may help explain the ways that minority stress impacts older lesbian women and gay men differently. This interaction implies that the negative relationship between stress and resilience is stronger for the men in this sample as compared to women.

As compared to older gay men, older lesbian women may experience a greater frequency of prejudicial events due to their triple minority status (Hughes & Hurtado, 2018; Yakushko et al., 2009). That said, contemporary American society often affords women more latitude in gender role deviation as compared to men (Prentice & Carranza, 2002). Although older gay men may hold fewer minority identities, the anti-gay prejudice they experience may

be of greater severity than that experienced by their female counterparts (Coston & Kimmel, 2012). Straight men, the most common aggressors of homophobic violence and discrimination, more strictly patrol and enforce gender norms than straight women. As gay men are often perceived to violate masculine gender roles, they are more likely to experience homophobic prejudicial events, including violence, than their female peers (Coston & Kimmel, 2012; D'augelli & Grossman, 2001; Grossman et al., 2001). If this is true, and older lesbian women experience a greater frequency of less severe prejudicial events, they may benefit more from the resilience bolstering effects of successfully navigating these events over time. Conversely, if older gay men experience fewer but more severe prejudicial events, they may experience a more heightened stress response to these events and be less likely to build greater resilience in response. If true, this might be a component of the interaction of gender and stress in this study, such that older gay men experience a stronger negative relationship between stress and resilience.

The older gay men in this sample reported lower income, lower education, higher stress, and lower resilience. About half of these men reported being HIV-positive, and about 40% held one or more ethnic minority identities. Post-hoc analyses did not reveal statistically significant relationships between HIV serostatus or ethnic minority status with resilience or perceived stress. An item-level analysis of gender differences on the resilience and perceived stress measures indicated that the greatest differences involved older gay men reporting fewer close relationships, less ability to cope with stressors, and feeling a lack of control over stressors in their lives compared to older lesbian women. A lack of statistical significance may be due to a small sample size, or it could be that these statistically "undetectable" differences still have a

compounding effect experienced in multiple levels of identity-based stigma and discrimination. According to Crenshaw's (1989) conceptualization of intersectionality, experiences of multiple minority stress are often more than additive. The stigma and discrimination associated with holding multiple minority identities may be even greater than the sum of racism, homophobia, and ageism.

Clinical Implications

LGBT resilience literature has flourished in recent years as social science researchers move away from deficit-based models of sexual orientation research to strength-based approaches. There are still gaps in the literature that examine gender differences between older lesbian women and gay men in the context of resilience. This study identifies an important gender difference in the relationship between stress and resilience. In the context of minority stress, clinicians must resist the tendency to view the LGBT community as a monolith. Case conceptualization and treatment planning should consider not only a client's sexual orientation, but the potential multiple minority identities the client holds. Clinicians must acknowledge the diversity within the LGBT community with an understanding that each of these identities, as in the case of older lesbian and gay adults, have different levels of salience to the client's identity.

It is clear that the older gay men in this sample do not experience the personal, social, and community support they need to thrive. Though the exact sources of identity-based stress for people with intersecting minority identities may be unclear, it is important for clinicians to acknowledge the ways that compounded minority stress can affect multiple systems and environments in the lives of older lesbian and gay people. The subjective experience of how

these identities interact will likely be different for each person, so treatment planning must include a broad understanding of how personal, social, political, and geographic considerations play a role in the discrimination older lesbian and gay adults experience.

This study highlights an important difference in the relationship between stress and gender for older lesbian women and gay men. Interventions that target improving resilience processes must be well-informed by the minority stress model (Meyer, 2003) and must acknowledge the different types, frequency, and severity of stressors older lesbian women and gay men experience. Sensitivity to this diversity of experience and acknowledgement of the structural factors that sustain homophobic social views is necessary to validate the identity-based stigma LGBT clients experience. While resilience is correlated with many positive mental and physical health outcomes (Davydov et al., 2010; Lyons, 2015), improving individual-level strengths must not be the only treatment focus. In their role as advocates, clinicians must work to address heteronormative and homophobic systems that allow or ignore discrimination and marginalization experienced by their clients.

As the Baby Boomers reach retirement age, there will be unprecedented need for social service resources to meet the needs of this large group of older adults. The population of LGBT Americans over 50 years old will surpass 5 million by the year 2030 (Choi & Meyer, 2016). It is unlikely that LGBT-specific agencies and programs can expand to meet this increase, so there is increased urgency for existing agencies and social service providers to adapt. Agencies should evaluate the LGBT-affirming training and resources available to their service providers to ensure that older LGBT people can find the services they need in a welcoming environment. As resilience is highly correlated with the strength of and access to social networks (Hildon et al.,

2008), programs that facilitate social connection are of the utmost importance at a time when loneliness and disconnection pose risks to the mental and physical health of older lesbian women and gay men. Social services agencies can help facilitate resilience in this population by designing programs that help older LGBT people maintain social, financial, and psychological stability in their lives during what is often a time of significant change.

Limitations and Future Directions

Research on resilience in the context of minority stress must examine the impacts of the multiple minority identities held by older LGBT people of color. Demographics data for the Dallas-Fort Worth Metroplex estimates Latinx communities comprise about 42% of the population, and Black or African American communities comprise about 24% (*U.S. Census Bureau*, 2019). Latinx participants only represent 8 percent of this sample. Although 27% of participants in this sample identified as Black or African American, only three were women. The lack of diversity here is partly due to sampling methodology. Participants were recruited from LGBT community centers, Gay Pride parades, and LGBT-affirming churches. Unfortunately, people of color experience racism within LGBT communities, and often do not feel welcomed by these institutions, especially in the American South (Worthen, 2018). While the recruiting strategy included working with organizations that primarily serve LGBT people of color, I found that older people were often excluded from these organizations. Future studies should work to include more participants with racial and ethnic minority identities with proportionate gender representation.

Additionally, those who participate in pride events and attend LGBT community centers are more likely to widely disclose their sexual orientation. This may have restricted the range

and variance of our measures as stress and resilience are likely different for those who conceal their sexual identity. Although people who conceal their sexual identity are difficult to access, future studies should utilize online networks and recruiting strategies that target the general population more broadly to increase visibility of research opportunities for those that do not frequently interact with LGBT-specific agencies and events.

While it is important not to artificially equate the identities and experiences of people who hold gender minority identities with those who hold sexual minority identities, the research team did attempt to recruit transgender and gender-diverse participants as part of this study. Only 12 transgender people participated, but due to a survey design issue, there was not an appropriate set of questions to assess their sexual orientation. As such, they were not included in the study. Much work is needed to include older transgender and gender-diverse people in social science research. Future studies should work with transgender advocacy organizations and service providers to improve participation of this often-overlooked community.

Participants provided self-report data electronically for this study, so the results are subject to error due to response biases and common-method variance. As with all cross-sectional research designs, the results of this study do not include causal inferences. It is also important to recognize the sociopolitical differences in the American South as compared to the American coasts, where most LGBT research is conducted. These differences were an important part of this research design, but results from this survey should be interpreted in the context of the sample described above and may not be generalizable to all older lesbian and gay adults.

Additional research on older lesbian and gay people in the American South is needed to replicate these findings or identify discrepancies.

APPENDIX A

EXTENDED LITERATURE REVIEW

Introduction

The Williams Institute estimates there are approximately 2.4 million LGBT adults over the age of 50 in the United States and that this number is likely to increase to over 5 million by 2030 as cited in Choi and Meyer (2016). As the country's largest generation, the Baby Boomers, begin to retire, this represents a dramatic shift in the number of older LGBT people who may need to access medical, social, and mental health services. Service providers must have the culturally-affirming training and competence to work with this group of older Americans, but evidence suggests a paucity of research addressing these needs as well as gaps in institutional education and training for working with older LGBT people (MacCarthy et al., 2021).

Though there are increased risks of adverse physical and mental health outcomes among older sexual minority men and women, there is much diversity among members of the LGBT community, many of whom have developed unique protective factors to ameliorate these risks. As a result, most older gay and lesbian people are physically healthy and psychologically well-adjusted (Fredriksen-Goldsen et al., 2014). As explained by the minority stress model, however, due to experiences of stigma and discrimination over their life course, many older lesbian and gay people experience depression, anxiety, loneliness, and stress at disproportionate rates compared to their straight counterparts (Meyer, 2003). Nevertheless, it is important to recognize the resilience older members of the LGBT community have built over a lifetime of successfully navigating social stigma, discrimination, and persecution based on their sexual orientation (Meyer, 2015). To understand how prejudicial experiences impact health and well-being and the strategies lesbian and gay people engage to counteract them, it

is essential to consider the historical context in which older sexual minority men and women grew up and formed their sexual identity (Dentato et al., 2014).

Despite many shared experiences among sexual minority adults, there are differences in the type of stress members of subgroups experience and in how they cope with or overcome these stressors. Lesbian women hold multiple minority identities, which in many cases interact to compound experiences of minority stress (Averett & Jenkins, 2012). Different age cohorts within older lesbian and gay populations have varied identity development experiences and interactions with social stigma (Rosenfeld, 1999). The purpose of this study is to examine these group differences in resilience and stress processes.

Theoretical Framework

Classic personality theories are often insufficient to explain the development of older LGBT people. For example, Erikson's theory of psychosocial development is one of the few personality theories to address development across the entire lifespan (Erikson, 1950/1993). A critical feminist analysis of this theory and others developed at the time identifies the androcentrism and classism intrinsic to it, which Sorell and Montgomery (2001) documented in the context of gender and racial bias. An examination of the unique challenges LGBT people face in each of Erikson's psychosocial stages reveals that it is similarly inadequate to fully explain developmental processes for sexual and gender minority communities across the lifespan. Kimmel (2015) investigates these challenges and proposes that, due to heteronormativity and social stigma, LGBT people rarely overcome the identity struggles of Erikson's theory only once. Instead, they encounter them many times across many contexts

throughout their lives. For sexual minority communities, questions of trust, shame, inferiority, identity, and intimacy, to name a few, are encountered at many life stages (Kimmel, 2015).

The homosexual [*sic*] identity model (Cass, 1979) was an early attempt at a stage theory of development of gay and lesbian people and was one of the first that approached sexual minority identity as a normal and healthy variation of sexuality. The model proposed six stages of identity development including confusion, comparison, tolerance, acceptance, pride, and synthesis. Common to many stage models, a criticism of this theory is its assumption that development is linear, sequential, and at some point complete, whereas, in reality, this is often not so of many people's developmental trajectories (Horowitz & Newcomb, 2002). Furthermore, this model was based on research with primarily with white men and, therefore, did not account for differences in experiences and identity development among different genders, ethnicities, or other intersectional identities (Chun & Singh, 2010). Thus, another model that explains the different trajectories and unique challenges LGBT people experience within the context of stigma and social stressors is required.

Minority Stress Theory

Ilan Meyer (2003) proposed a minority stress model to explain the increased prevalence of negative mental health outcomes in LGBT communities compared to their straight and cisgender peers as attributable to the stressful social context of homophobic discrimination and stigma. With consistent exposure to this stigma, some lesbian, gay, and bisexual people turn these negative societal attitudes inward, resulting in internalized homophobia, a type of personal shame about one's sexual identity (Meyer, 1995). Minority stress theory encompasses three primary processes of a) experiencing stressful events, b) vigilance in expectation of these

events, and c) internalization of social stigma at the root of these events (Meyer & Frost, 2013). For example, based on past experiences of minority identity-based rejection, one might automatically expect such rejection from others and, over time, come to believe that they are less worthy of acceptance and validation because of their sexual orientation.

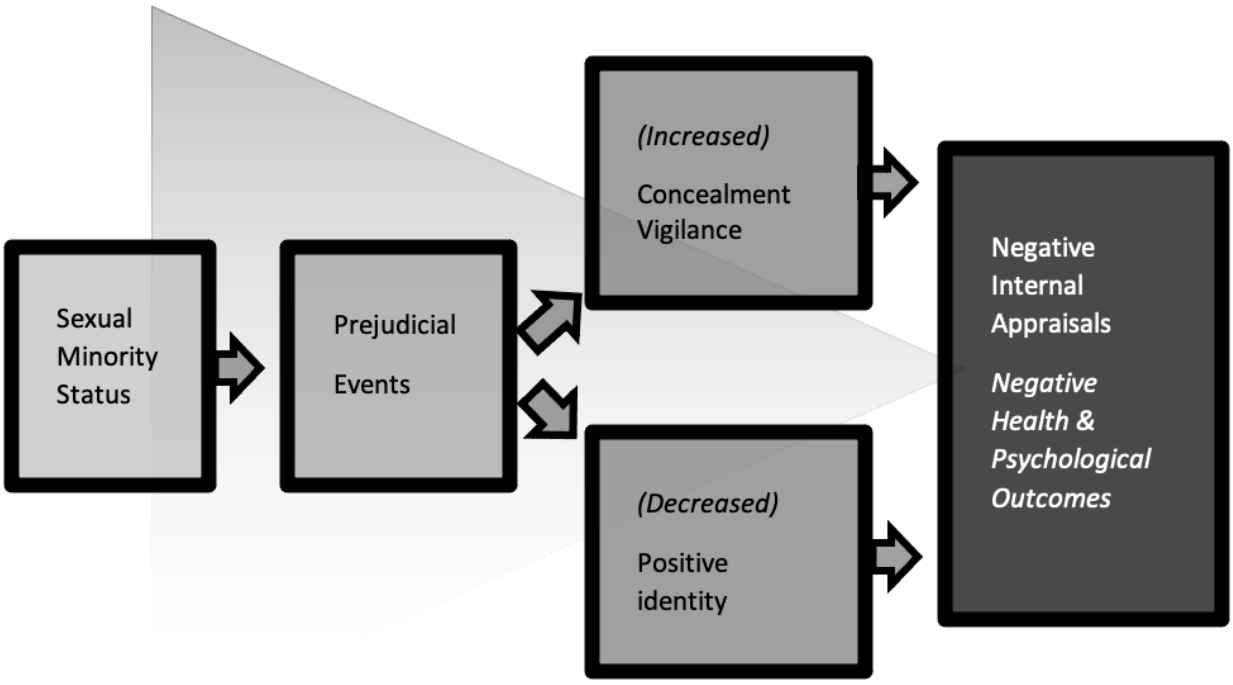
These stressful events range from seemingly mundane interactions with a heteronormative society to experiences of overt homophobia (Meyer et al., 2011). Accounting for the total impact of these stressors across the lifespan explains the disproportionate prevalence of adverse mental health outcomes such as depression, anxiety, suicidality, and substance use among sexual minority adults as compared to their straight peers (Diplacido, 1998; Fredriksen-Goldsen et al., 2014; Meyer, 1995). Social stigma as a catalyst for discrimination against sexual minority adults in employment, housing, and access to social services accounts for disparities in financial wealth and economic instability (Mallory et al., 2017). The frequency and degree to which generational cohorts experience these stressors are dependent upon the social climate at the time and place of critical phases of identity development (Grov et al., 2018) and the degree to which they disclose their sexual identity (Legate et al., 2012).

Minority stress presents challenges to positive identity development, such as identity pride and identity synthesis, stages five and six of Cass's (1979) homosexual [*sic*] identity model. Fredriksen-Goldsen et al. (2017) found that older lesbian and gay people with a positive appraisal of their identity had better social resources, mental health, and physical health than those with poorer identity appraisals. In the same study, marginalization experiences predicted lower available social resources, but only for those with an open identity management style

(i.e., those who are the most "out" about their sexual orientation). This finding suggests that highly visible older lesbian and gay people may be disproportionately ostracized, thus negatively impacting their social resources. Nevertheless, Meyer (2011) also found that positive identity development often comes about in response to battling stigma against marginalized identities and the resulting growth of social cohesion and personal power. In other words, resilience often develops in response to minority stress and, for some, may counteract its negative impacts on identity development. At the same time, however, minority stress theory cautions against conceptualizing resilience to minority stress solely in the context of individual-level traits and coping skills, as this may detract focus from the responsibility of society to address discrimination and protect disadvantaged populations (Meyer, 2015).

Figure 1

Minority Stress Model



Note: This model depicts the negative impacts of sexual identity-based prejudicial events on psychological outcomes among sexual minority people.

Kwate and Meyer (2010) also explain that because individual-level expectations neglect the importance of equity in public policy, it can lead to policy implications that increase exposure to stressful events and their related negative mental health outcomes. Thus, rather than focusing solely on the distinction between a person as a victim or a resilient actor, Meyer (2013) notes the importance of acknowledging both the subjective experiences of minority stress and the objective stress-inducing social environment. A focus on the latter, he suggests, has a greater impact on the well-being of a minority community in general and places less burden for change on its members. Figure 1 provides a visual depiction of the minority stress model as applied to this study.

The Transactional Model of Stress and Coping

Lazarus and Folkman (1984) developed the transactional model of stress and coping to explain cognitive appraisal pathways and coping with stressful events in the person-environment relationship. In the context of aging LGBT people, this model helps clarify differences in appraisals of stress and coping responses compared to their straight or younger counterparts and the impacts of these processes on individual-level resilience factors. According to the model, in the cognitive appraisal process, a person evaluates whether and to what extent an experience (a transaction) is stressful. Coping involves the process by which one deals with the emotional demands the stressor places upon them. Within this model, stressors are categorized as either distal (social structures) or proximal (personal social experiences). Relevant to minority stress theory, distal stressors include the awareness of heterosexism and exposure to negative social attitudes that LGBT people encounter (Meyer & Frost, 2013). Proximal stressors arise due to their saliency to the person's subjective experience, perceptions,

and expectations. In the context of minority stress, distal social structures initially become proximal stressors when individuals first label themselves as gay or lesbian and must evaluate the intrinsic relevance of negative societal messages (Meyer & Dean, 1998).

The transactional model of stress and coping features a cyclical process of appraisals and responses to stressful stimuli. In the *primary appraisal* process, a person labels an encounter as either (1) *irrelevant*, in which they judge it to bear no consequences toward a person's well-being, (2) *benign-positive*, indicating that the encounter serves to either maintain or enhance well-being, or (3) *stressful*, which involves a perception of potential harm, loss, threat, or challenge (Lazarus & Folkman, 1984, p. 32). For example, suppose a gay or lesbian person encounters a homophobic slur. In that case, the primary appraisal might include assessing the relevance of the slur to one's identity, the importance or perceived power of the actor, and an interpretation of why the slur might have been used as components of understanding potential consequences to one's well-being. Even if the slur is not overtly directed at the person, but it negatively references an attribute or characteristic with which the gay or lesbian person identifies (e.g., effeminate or butch) and is used by the person's boss in front of other colleagues, this is a situation in which there are potential consequences to personal well-being. The appraisal in this situation is most likely stressful. A stressful primary appraisal is usually followed by a *secondary appraisal*, in which one evaluates available coping resources, potential options, and the likelihood of successfully overcoming or resolving the encounter. In the secondary appraisal of the previous homophobic slur example, one might assess their relationship with their employer, the safety and social climate of their workplace, and their previous experiences resolving similar encounters in the past in determining their

capacity to cope with this encounter. The final stage in this process is *reappraisal,* in which a person, having considered their available coping resources, options, and the likelihood of success, reappraises whether the encounter is irrelevant, benign-positive, or stressful. In the example of the homophobic slur, if the person determines that their boss cares about their well-being and is open to feedback from employees, their peers are supportive, the work climate is generally affirming of LGBT people, and they feel comfortable addressing the homophobic slur, they might reappraise this encounter as benign-positive.

Lazarus and Folkman (1984) account for different environmental conditions and individual differences in stress vulnerability, appraisal, and reactions. However, the primary stressors explored in their model are related to role conflicts, performance, negative interpersonal exchanges, and social structure as opposed to stress from identity-based stigma and discrimination. Major et al. (2003) used a transactional framework to incorporate stress and coping responses in the context of threats to personal identity. The authors propose that *attribution* plays an essential role in the appraisal process. If a person attributes an identity-based threat to unjustifiable discrimination, self-esteem is protected, and self-blame is less likely (Major et al., 2003). In a similar vein, Berjot and Gillet (2011) propose that efforts to protect and enhance personal and social aspects of identity play an important function in coping with identity-based discrimination. For example, one might deepen contacts within their in-group, publicly reaffirm their identity, resist negative social constructions of sexual minority identities, or re-evaluate a threatened identity characteristic by its positive attributes. With these adaptations, the transactional model of stress and coping fits the person-environment emphasis of the minority stress framework to explain the effects of resilience against sexual

identity-based discrimination.

Historical Context

Psychological research in the 20th century reflected the negative views of LGBT people by medical and mental health professionals during that time, which pathologized members of sexual and gender minority communities. Early versions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) informed this research framework with the inclusion of non-heterosexual identities as mental disorders. Paraphilic disorders included a diagnosis of homosexuality [*sic*] in the first edition of the *DSM* (American Psychiatric Association, 1952), included "sexual orientation disturbance" in the second edition (American Psychiatric Association, 1973), then ego-dystonic homosexuality [*sic*] in the third edition (American Psychiatric Association, 1980). It was not until 33 years later, with the removal of gender identity disorder in *DSM-V*, that the American Psychiatric Association (2013) eliminated the final remnants of official LGBT identity pathology.

Alfred Kinsey's landmark publication "Sexual Behavior of the Human Male" (Kinsey et al., 1948/2003) was critical to both bringing visibility to and normalizing gay and lesbian relationships and sexual behavior. Legal and social change, however, would still lag far behind these emerging scientific discoveries. The early psychological research framework still bolstered homophobic and transphobic sentiments in American society in the 1950s to 1970s, which viewed members of sexual minority communities as sexual perverts, criminals, and even communists (Messinger, 2006). Oppressive homophobic legislation persisted well into the 21st century. It was out of needs for literal and social survival that LGBT people became very skilled at hiding their identities, and in many cases, denying it even to themselves (Clunis et al., 2005).

At a time when gay people experienced physical violence and arrests by police, it was not uncommon for gay and lesbian people to marry someone of the opposite gender as a means of identity concealment and gender role conformity (Butler, 2004). The reduction and ultimate removal of pathological references to sexual orientation from each subsequent version of the *DSM* and the substantial efforts of the psychiatrists and psychologists who advocated for these changes, however, helped set into motion the significant advances in civil rights and social acceptance of lesbian and gay people in the following decades (Drescher, 2015).

Lesbian and gay people born in the United States in the 1970s and earlier faced substantial legal, social, and physical threats in the form of state-sponsored persecution due to the marginalization and discrimination of these communities at the time (Field, 2018). The 1969 Stonewall riots in New York were a series of violent confrontations between police and LGBT people, which began in reaction to the repeated arrests of patrons at gay nightclubs, but developed into a days-long protest of discrimination against LGBT people in America. The riots marked a significant change in the trajectory of the movement for LGBT equality given the level of resistance and violence, publicity, and persistence (i.e., lasting nearly five days) (Faderman, 2015). So significant was the socio-historical relevance of the riots that Rosenfeld (1999) suggested the delineation of pre- and post-Stonewall age cohorts among older LGBT Americans due to the distinct cultural, political, and social changes following the riots. The riots and subsequent protests brought visibility to the second-class citizenship status of LGBT and spawned hundreds of gay activist organizations across the country. This visibility also brought about a backlash from anti-LGBT people, religious groups, politicians, and law enforcement, who increased raids and arrests at gay clubs across the country (Field, 2018).

Older LGBT people experienced drastic shifts in the political and social climate in the 21st century with the abolishment of laws that criminalized homosexuality [*sic*] (*Lawrence v. Texas*, 2003) and denied federal benefits for same-gender spouses (*United States v. Windsor*, 2013). Other LGBT-affirming changes included the addition of protections for LGBT people under public accommodations laws (*Masterpiece Cakeshop v. Colorado Civil Rights Commission*, 2018), employment protections under Title VII of the Civil Rights Act of 1964 (*Bostock v. Clayton County*, 2020), and legal recognition of marriage equality in all 50 states (*Obergefell v. Hodges*, 2015). Nonetheless, substantial advances toward equality under the law for LGBT Americans often provoke political pushback. In the aftermath of the marriage equality rulings, anti-LGBT politicians mounted lawsuits and proposed state and federal legislation in the form of religious freedom exemption bills, 10th Amendment lawsuits citing federal over-reach of states' rights, and proposed new bills to limit LGBT protections not covered by the Supreme Court rulings (Faderman, 2015).

The AIDS crisis of the 1980s and 1990s was a trying time for gay men. Nearly 450,000 friends, partners and loved ones died of AIDS by the year 2000 (U.S. Centers for Disease Control, 2001). The crisis decimated the thriving LGBT communities in urban areas and further stigmatized gay men as being diseased or sick (Siegel et al., 1998). Tester (2018) found that any older gay men, particularly those in large urban areas, cite the AIDS crisis as a major cause of poor social and community support and feelings of loss. Having survived the AIDS crisis, however, many older gay men also report that the grief and depression they experienced at the time led to discoveries of self-awareness, confidence, and meaning in life (Tester, 2018).

Though the American political landscape has changed dramatically across the lifespan of

older LGBT people, researchers must view the impact of these developments on the lives of older LGBT people in a geo-cultural context. When progress toward LGBT equality advances utilizing local and state legislation or by voter mandate, it often reflects changing societal views and may serve to reduce existing anti-gay attitudes (Flores & Barclay, 2016). However, federal judicial action has little impact on the perspectives of those who previously held anti-LGBT social views (Redman, 2018).

In the American south, expansion of LGBT rights has historically been slower than the rest of the country and less likely to occur through state legislation or voter action. As such, these advancements are often at odds with prevailing social views in the South. As a case in point, despite the recent rapid expansion of rights for LGBT people at the national level, state legislators in Texas, where participants in the present study lived, introduced 32 bills to limit rights and protections for LGBT people, more than any other U.S. state in the 2021 legislative session (Equality Texas, 2021). Whether or not these bills become laws, they represent the prevalence of negative social attitudes toward LGBT people and active efforts to marginalize them further. Moreover, the political conversation and campaigns related to LGBT rights can take a toll on LGBT people. A media study tested the psychological effects on LGBT people of ads with negative messaging about marriage equality initiatives during the 2012 presidential election (Flores et al., 2018). The study included 12 states, though only four were affected by marriage equality initiatives (i.e., Maine, Maryland, Minnesota, and Washington). The other eight were in the same media markets, which also aired the ads. Even in states unaffected by marriage equality initiatives, LGBT people exposed to the negative messaging reported higher levels of sadness and a lower likelihood to smile or laugh during the October-November

campaign period. Importantly, the issue on these referenda was a proposed expansion of LGBT rights, as opposed to the 32 bills in Texas, which propose to limit existing rights and protections.

Resilience

Resilience is a hallmark strength of LGBT people who have overcome decades of marginalization and discrimination. Resilience is associated with increased social support, self-esteem, general health, psychological well-being, and lower reports of anxiety, depression, and loneliness (Fredriksen-Goldsen, 2011; Lyons, 2015; Reisner et al., 2014). An emphasis on resilience within LGBT communities in emerging scientific literature reflects a shift toward strengths-based theories of LGBT psychology, and away from deficit-based theories (Herrick et al., 2014; Ramirez & Sterzing, 2017). Indeed, many LGBT people have successfully worked through the challenges of the coming out process, overcome social stigma, and navigated discrimination throughout their lifetime (Schope, 2005). Resilience in the face of such adversity is admirable; and it is important to recognize that this resilience has often come out of necessity and at a significant cost (Russell & Richards, 2003). Meyer cautions against an expectation of such resilience. He warns that victim-blaming can occur by suggesting that "because an individual *can* be resilient, we risk expecting that individuals *ought* to be resilient" (Meyer, 2015, p. 211).

Views in social science literature vary, with some describing resilience as the result of a positive appraisal style (Kalisch et al., 2014), a teachable skill (Richardson & Waite, 2002), a defense mechanism (Davydov et al., 2010), or a function of personality (Oshio et al., 2018). Perhaps most consistent with a minority stress lens relevant to the experiences of LGBT people confronting social stigma and discrimination is a definition of resilience as both "positive

adaptation in the face of adversity and risk" and as "a process" (Herrick et al., 2014, p. 2). This view suggests that, rather than an innate set of attributes, resilience is built over the life course and is adaptive with each challenge overcome. This process-oriented framework emphasizes protective factors that foster resilience (Barrow et al., 2007). Bronfenbrenner's (1979) ecological systems theory describes the reciprocal nature of person-environment relationships at various levels of social structure. According to this theory, a microsystem is the environment closest to the individual, as in home or school. In contrast, the macrosystem encompasses the overarching social, cultural, political and ideological patterns which influence the micro-, meso-, and exosystems (Bronfenbrenner, 1979, pp. 7-8). Conceptualizing this process-oriented approach to the development of resilience within an ecological systems framework helps explain the unique factors that influence resilience in LGBT communities and group differences within them.

Older people in the population at large experience higher levels of resilience and overall wellness than their younger peers (Fullen & Granello, 2018), and the same is true of lesbian and gay older adults (Fredriksen-Goldsen et al., 2011). This is remarkable given the increased physical and mental health disparities older sexual minority adults face compared to their straight peers, including disability, obesity, depression, and loneliness (Fredriksen-Goldsen et al., 2011, 2013; Meyer, 2003). Higher levels of resilience for gay and lesbian older adults compared to their younger gay and lesbian peers may be due, in part, to the more extensive social networks they have created over time, as well as their greater degree of independence and better access to LGBT community resources (Huebner et al., 2004; Kertzner et al., 2009). Older lesbian and gay adults have encountered and often have successfully overcome more

experiences of stigma and discrimination in their lifetime, which can bolster resilience in the face of new experiences of minority stress (Crisp et al., 2008; Meyer, 2003). As compared to their younger peers, resilience buffers many of the disparate identity-based mental health risks faced by lesbian and gay people, internalized stigma, discrimination, and victimization (D'augelli & Grossman, 2001).

The Stonewall Riots in 1969 represented a significant developmental milestone for lesbian and gay people coming of age at the time. It marked the beginning of the gay activist revolution and a change from the silence and invisibility characteristic of the previous age cohort (Rosenfeld, 1999). This new age of activism began to steadily change previously held notions of family, relationships, opportunity, and self-worth for LGBT people (Dentato et al., 2014). It was still a challenging and dangerous environment to disclose one's sexual minority identity, which many of today's Baby Boomer generation (born 1946-1964), and to a lesser extent, the Greatest Generation (born 1925-1945), did despite the risks. Therefore, it is important to examine cohort differences in resilience among older sexual minority adults, specifically in the context of Stonewall (Parks, 1999; Rosenfeld, 1999). Rosenfeld (1999) identified the Pre-Stonewall identity cohort as those born before the mid-1950s, whose sexual identity developed when deficit-based theories, pathology, and criminalization dominated the discourse about sexual minorities. Consequently, prior to the Stonewall Riots, disclosing one's sexual orientation was less common, which both protected against much of the social derision at the time but also deprived them of the critical benefits of belonging, social support, and identity cohesion that often accompanied disclosure (Rosenfeld, 1999). Additionally, coming out during the tumultuous social and political context in the 1960s and 1970s led to the

development of what Kimmel (2002) called "Crisis Competence." That is, having faced and survived the heightened stigma, exposure to violence, and threats of job loss and social ostracization that sometimes accompanied sexual identity disclosure in the 1960s and 1970s, people developed resilience to future threats and a higher bar for encounters they label as threats (Kimmel, 2002). The effects of identity concealment and internalized shame likely account for differences in resilience between the Pre- and Post-stonewall cohorts.

Stress

Minority stress and general stress are different in that the latter may be chronic or acute (situational), whereas minority stress is chronic due to its relation to stable social and cultural structures (Meyer, 2003). Crocker (1999) explains that this difference is due to the chronic nature of the stigmatizing social environment, even in the absence of an actual stigmatizing or discriminating event. Minority stress and general stress are related in that minority stress is additive to general stress, thus increasing the stress response to many of the same stressors that all people face (Meyer, 2003). Allport (1954) described vigilance as a defensive coping mechanism that minority communities use to prepare for and protect against social stigma and discrimination. In response to chronic minority stress, vigilance results in LGBT people remaining in a state of constant alert, thus compounding the stress response (Crocker & Major, 1998).

Though most LGBT people report being in good health, the accumulation of stigma- and discrimination-related stressors across the lifespan is related to poorer reports of overall general health in older lesbian women and gay men (Fredriksen-Goldsen, Kim, Bryan, et al., 2017; Lyons et al., 2019; Meyer, 2003) Moreover, sexual minorities experience disparities in the

prevalence of adverse physical and mental health such as disability, cardiovascular disease, anxiety, depression, and suicide (D'augelli & Grossman, 2001; Fredriksen-Goldsen, 2011; Kertzner et al., 2009; Meyer, 1995). Minority stress, discrimination, and internalized homophobia are also associated with increased risks of maladaptive coping mechanisms such as smoking, alcohol, and drug use (Averett et al., 2011; Choi & Meyer, 2016; Fenkl, 2012; King et al., 2008).Though resilience helps protect against stress and its related adverse health outcomes, it is not a panacea.

For gay and lesbian people of color, the stress associated with homonegativity and identity-based discrimination is even further compounded. Crenshaw (2018) argued that combined stress associated with multiple minority identities is not just additive, but that discrimination from multiple systems of oppression intersect such that these experiences of discrimination are greater than the sum of their parts. For Latinx men, this stress is associated with psychological distress, poor general health, and sexual risk behaviors (Nakamura & Zea, 2010). The stigma Black men experience from within Black communities, and the racism they encounter in LGBT communities are detrimental to social and community support, and often prevent them from seeking HIV prevention services (Haile et al., 2011). Associated with compounding minority stress, Black women report lower health-related quality of life than straight White and Black women as well as lesbian White women (Cohen & Murray, 2006).

Gender

Despite commonalities in their encounters with sexual minority-based marginalization and discrimination, researchers must not assume that older lesbian women and gay men experience the same types of discrimination events or that they are affected by and cope with

these experiences similarly (Averett & Jenkins, 2012). Acknowledging commonalities between older lesbian women and gay men should not mean ignoring differences, particularly given the patriarchal social and political structures in the U.S. that contribute to the invisibility of women, including within LGBT communities (Brown, 2009). Although studies on older LGBT people have increased in recent years, this is still an emerging field of research. Furthermore, research specific to the intersections of age, sexual orientation, and gender remains scarce.

For members of multiple intersecting minority communities, each of these minority statuses has varying degrees of salience to their identity (Yakushko et al., 2009). For older lesbian women, this diversity of identity salience may also play a role in the frequency, degree, and types of discrimination they encounter (Hughes & Hurtado, 2018; Yakushko et al., 2009). Having experienced some degree of discrimination across their lifetimes based on each of these identities, however, older lesbian women may have developed more coping mechanisms and greater resilience than older gay men as a result (Lyons et al., 2019). In addition, the triple invisibility of older lesbian women, along with the sexual fetishizing of lesbian women by straight men (Diamond, 2005; Kehoe, 1986), may play a role in older lesbian women reporting fewer experiences of homophobic discrimination as compared to older gay men (Lyons et al., 2019).

Research findings on gender differences in stress levels between men and women in the population at large are mixed, and differences are often context-dependent (Juster et al., 2019; Matud, 2004; Thoits, 1982). The contexts under which women report higher levels of stress are often related to gender roles and family structures (Juster et al., 2019; Matud, 2004), situations that may be markedly different for gay and lesbian people. That said, discrimination predicts

higher psychological distress and poorer physical health among gay men compared to women, although the directionality of the relationship between discrimination and poor health is unclear (Lyons et al., 2019). This stronger relationship between discrimination and psychological distress for gay men may be due to more effective emotion-focused coping styles leveraged by women (Matud, 2004) or differences in the types of discrimination gay men and lesbian women experience.

Older gay men are more likely than lesbian women to experience acts of violence due to sexual orientation discrimination across their lifespan, usually by straight men (D'augelli & Grossman, 2001; Grossman et al., 2001). Such violence may be due to homophobia combined with particularly narrow perceived social norms for expressions of masculinity (Coston & Kimmel, 2012). Considerations of historical context are also essential here, as homophobic laws, such as those criminalizing sodomy, targeted gay men more directly than lesbian women. The AIDS crisis of the 1980s was particularly impactful in the lives of older gay men in many ways. Whether they had AIDS or not, they were targets of the social stigma and political polarization of the AIDS crisis (Meyer, 1995). Homophobia in social and political discourse predicts the internalization of identity-based shame. It is not surprising then that older gay men report higher levels of internalized homophobia than their lesbian agemates (Grossman et al., 2001), or that the relationship between discrimination and wellbeing is stronger for men than women (De Graaf et al., 2006).

APPENDIX B

ADDITIONAL FIGURES

Figure B.1

Scatterplot Matrices Testing Linearity of Dependent Variable and Covariates

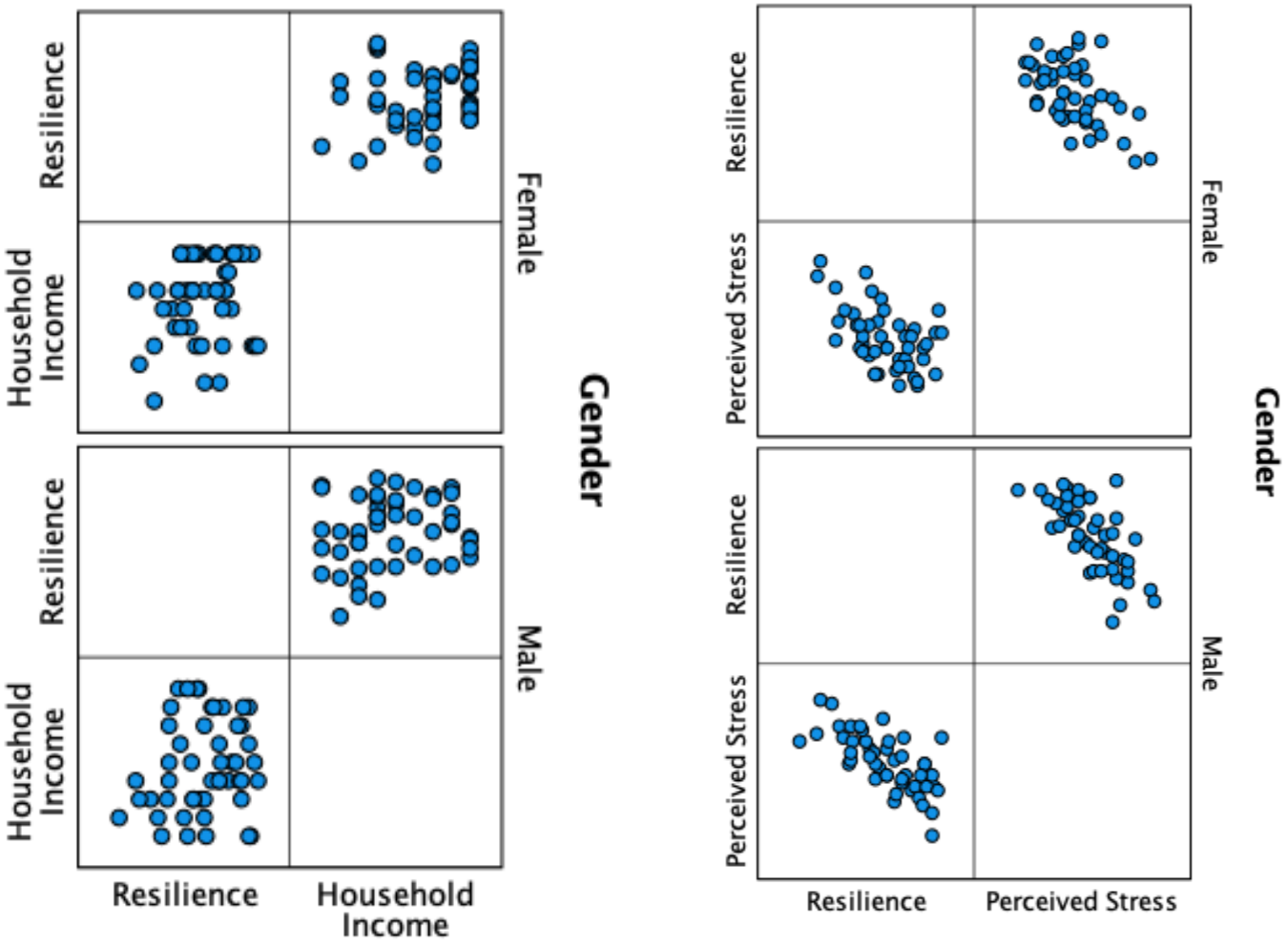
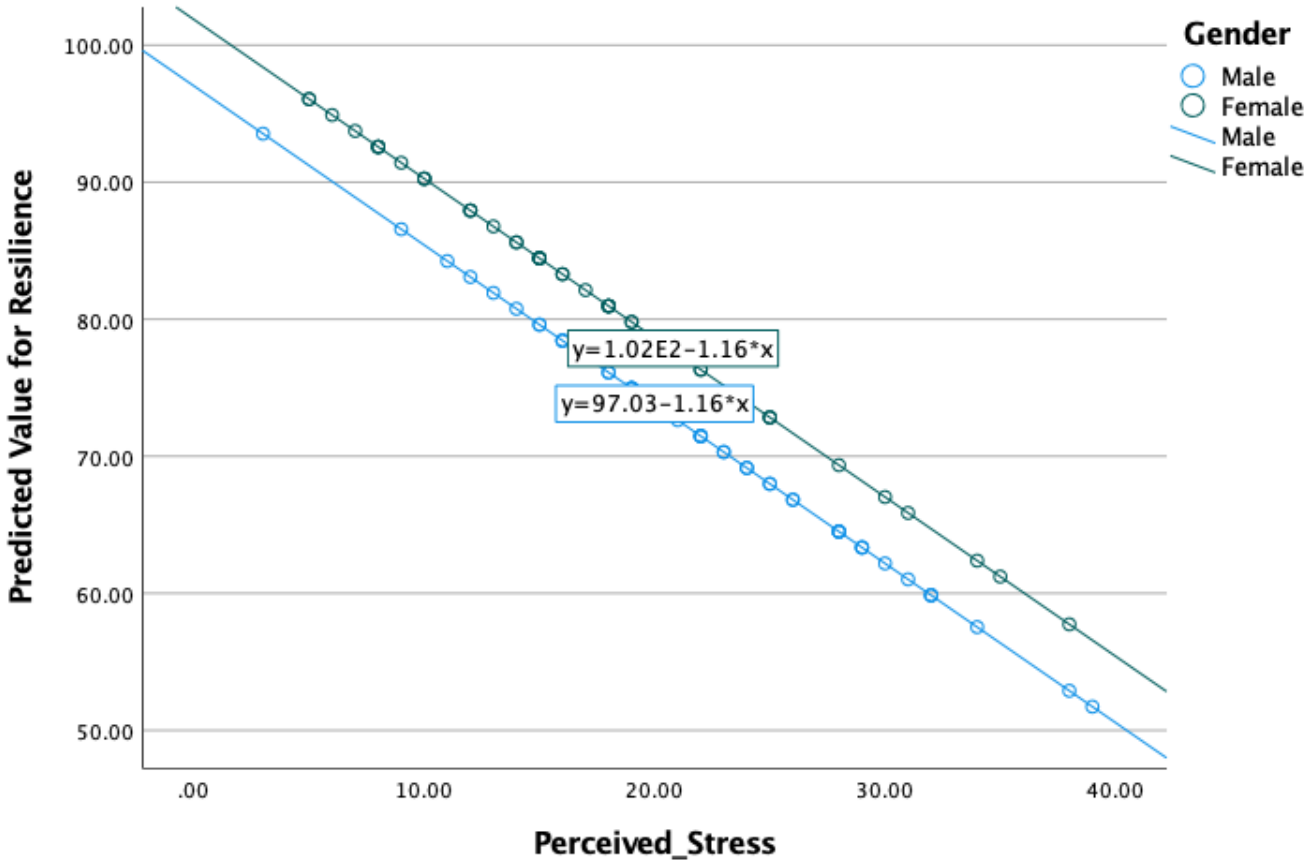


Figure B.2

Interaction Plot of Gender and Perceived Stress on Resilience



APPENDIX C

GRAY PRIDE INFORMED CONSENT

University of North Texas Institutional Review Board
Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Project Gray Pride

Principal Investigator: [redacted], Associate Professor, University of North Texas (UNT), Department of Psychology, Division of Counseling

Purpose of the Study: You are being asked to participate in a research study which involves the completion of a survey which addresses issues such as health conditions, health-related behaviors, and various psychological and social factors. This information will be used to better understand factors associated with aging in sexual and gender minorities.

Study Procedures: You will be asked to complete a comprehensive computer-based questionnaire that will take about 2 hours of your time. The questionnaire includes questions about both your physical and your emotional health, experiences coming out, stigma related to sexual and gender identity, trauma history, factors contributing to successful coping, and questions about overall quality of life.

Foreseeable Risks: The topics addressed throughout the course of the study may prove a source of emotional discomfort. Although unlikely, survey questions may trigger anxiety, stress, fear, confusion, embarrassment, depression, or guilt. Upon completion of the survey, you will be given toll-free phone numbers to crisis lines and low-cost mental health services to assist in event of distress.

Dallas Metrocare Services Counseling Clinic	214-743-1200 #0
University of North Texas - Dallas Campus	972-780-3646
University of North Texas Psychology Clinic	940-565-2631
Parkland Health and Hospital System -	214-590-8761
The Psychiatric ER	817-267-3731 ext.2631
Galaxy Counseling Center	972-272-4429

Benefits to the Subjects or Others: Although no benefits are promised, you may gain some insight into your emotions. Findings from this study may inform the development of treatments and communications to improve health-care for older sexual and gender minorities.

Compensation for Participants: As incentive for your participation, you will receive $25.

Procedures for Maintaining Confidentiality of Research Records: Data collection for the survey

questions will be conducted in a private area at the Resource Center of Dallas, or at the Center for Psychosocial Health, a computer laboratory in Terrill Hall, room 284, at the University of North Texas. These locations will ensure your confidentiality. Once enrolled in the study you will be assigned a participant code number that will be used in all data collection. No one outside of the PI and office manager will have access to any data or information associated with the project or participants. The data will be de-identified and also be kept on a password-protected computer by the office manager and the PI. All data will be secured and accessed only by research staff. To maintain confidentiality of the information provided, all data will be secured in a locked office in the Center for Psychosocial Health Research at UNT. Should data pertaining to this research be published, your identity will not be revealed. At the conclusion of this survey, you will be asked if you would like to provide the names of other potential participants in this study, but you have the right to decline to provide this information.

Voluntary Participation: Participation in this research study is voluntary and you are free to withdraw your consent at any time without penalty or losing benefit to which you are otherwise entitled.

Questions about the Study: If you have any questions about the study, you may contact the Center for Psychosocial Health by phone at [redacted] or contact the Department of Psychology at [redacted] or by email at [redacted].

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at [redacted] with any questions regarding the rights of research subjects.

Research Participants' Rights:
Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- A designated research assistant from the Center for Psychosocial Health Research has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

For the Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

_____ _____

Signature of Investigator or Designee Date

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